STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	010885	A. BUILDING: _____ B. WING _____	C 06/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND	**2715 CHARLESTOWN PIKE JEFFERSONVILLE, IN 47130**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00172886. Complaint IN00172886 - Substantiated. No deficiencies related to the allegations are cited. Survey Date: June 2, 2015 Facility Number: 010885 Provider Number: 010885 AIM Number: NA Survey Team: Gloria J. Reisert, MSW, TC Census bed type: Residential: 105 Total: 105 Census payor type: Medicaid: 43 Other: 62 Total: 105 Sample: 05 Riverbend was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00172886.	R 000		